Medical Care in Correctional Institutions: The AMA Project

HERBERT C. MODLIN, M.D.*

The past twenty years have witnessed growing concern and attendant publicity for the medically underserved, including those needing psychiatric services. The list of underserved “populations” has become standardized — children, aged, minorities, urban poor, rural, chemically dependent. In the last five years the “chronic mental patient in the community” category has been added to the psychiatric aspect of the list.

None of the organized groups concerned with the medically deprived, from Congress and HEW on down, has considered the legally incarcerated; even though in some respects they may be the most ignored, medically and psychiatrically. The title of a recently published book suggests it: The Fourth World: The Imprisoned, the Poor, the Sick, the Elderly and the Underaged in America.¹ Most of the imprisoned are poor; a disproportionate number are from minority groups; sixty per cent of them are ill; and a distressing number are under eighteen years of age.

The American Medical Association has long been actively engaged in efforts to improve medical services for the nation’s medically underserved. Collectively we have initiated programs, published papers and monographs, devised publicity, and testified before Congressional committees on behalf of migrant workers, the American Indian, the center city poor, the mentally retarded, the alcoholic and the mentally ill. Consequently, when we were asked by the American Bar Association to become interested in the plight of the incarcerated, the request fell on receptive ears.

In 1971 representatives of the Commission on Correctional Facilities of the American Bar Association expressed their concern to the AMA about the poor quality of medical services in correctional institutions, particularly in jails. Discussions with members of the National Sheriff’s Association and the American Correctional Association clearly showed that the problem was serious. To acquire more accurate data than any available, staff members composed and submitted to 2,900 sheriffs a four-page questionnaire on medical services. Surprisingly, sixty-nine per cent responded, painting a dismal picture of health care conditions in their respective institutions. Respondents variously expressed discouragement, concern, indignation and hope in their descriptions of outmoded facilities, inadequate staffs, limited funds, and uninterested doctors.

Impressed by information gleaned from the questionnaire, the AMA’s

¹Dr. Modlin is Chairman, AMA Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions.
Board of Trustees allocated $50,000 for preliminary study and planning of a program to improve medical care in jails. In 1974, the Law Enforcement Assistance Administration (LEAA) indicated definite interest, and, with the help of LEAA staff, a three-year pilot project was fashioned and refined; full time staff with expertise in corrections was hired; and a national advisory committee was appointed. A grant request was submitted and approved for funding by LEAA. Day One of the project was April 1, 1976.

As finally endorsed by LEAA, the program was composed of three major subprograms: (1) development of model health care delivery systems for jails; (2) construction of minimal standards and implementation of a national certification program for jails; (3) establishment of a national clearing-house of information on jail health services. An independent research organization was engaged to monitor and evaluate the program as it proceeded.

Shortly after receiving the grant, the AMA sent a descriptive announcement to all state medical societies, requesting that each interested society submit a plan for participating in the study, utilizing selected jails in its state. Because of our fund limitations, only six states were to serve as subgrantees of the major pilot project. The successful applicant states were Indiana, Michigan, Wisconsin, Georgia, Maryland, and Washington. Each of the selected state medical societies appointed a medical advisory committee and hired a project director who, in turn, selected from three to seven jails in his state as pilot sites.

Jails and Inmates

The next step was to develop a “Before” profile of the jails and their existing health care delivery systems. That form of data collection was twofold in purpose: First, information obtained would help the states to identify deficiencies in their jails and facilitate their designing of model health care delivery systems to correct them; second, the data would constitute the base line profile against which any subsequently evolving changes in delivery systems could be measured.

In the thirty jails surveyed, the average daily population ranged from four to 1,500, and the number of inmates received each year ranged from a low of 220 to a high of 68,000. Nearly one-third were badly overcrowded, and there were many glaring deficiencies in the health services. Less than half of them provided a regular sick call. Twenty-seven per cent lacked any emergency equipment, and in six per cent there was not even a first-aid kit. Only slightly over thirty per cent had any written policies regarding the delivery of health care to inmates, and sixty per cent maintained no medical treatment records whatever.

Examining the inmates was our next step in gathering data which might indicate specific medical services needed. Each of the six states organized volunteer teams of physicians and nurses and medical technicians to evaluate a representative group of inmates. The examination of 641 inmates in 28 pilot jails included a health history, physical examination, laboratory tests, and each inmate’s assessment of the current care delivery system in the jail holding him.

Data collected from that part of the project replicated those in our 1972 survey. The majority of inmates never had been given a physical examination.
and ninety per cent never had been to a dentist or had their eyes tested. Eighteen per cent reported having used heroin on a daily basis, and fifty per cent reported daily intake of alcohol prior to incarceration. Many described having experienced severe withdrawal symptoms during their first few days in jail.

Concerning communicable diseases, 12½ per cent of the 641 inmates had an abnormal tuberculosis test, and six per cent had positive tests for syphilis. Findings of abnormal liver function in thirty per cent suggested rampant hepatitis. In 12.4 per cent, urine abnormalities were observed.

Ninety per cent of the inmates voiced at least one medical complaint, and the medical examiner recommended some type of follow-up medical care for sixty per cent of them. Physical examinations revealed about three abnormalities per inmate, one in every three serious enough that the medical examiner recommended follow-up treatment; most of them had not been identified or treated previously.

**Judicial Influences**

Prior to the 1970's, inmates seeking adequate medical and psychiatric services met entrenched barriers in the judicial system, not to mention in the penal system. A “hands off” policy was enunciated in court decisions, based on the positions that courts had no authority to review local jail administration, or lacked expertise in penology, or were reluctant to subvert prison discipline. The leading case in reversing these attitudes is only seven years old. In *Newman v. Alabama* (1972) the federal district court held for the first time that serious deprivation of proper medical treatment disregarded the Eighth Amendment’s prohibition of cruel and unusual punishment. Understaffing, poor equipment and facilities, unqualified personnel, and inept administration were cited by the court as evidences of grossly inadequate medical care.

A series of judicial decisions have since addressed the general and medical rights of inmates and declared them entitled to competent medical and dental care, medications and medically prescribed diets, professional evaluation and treatment of psychiatric disorders, drug and alcohol detoxification and follow-up treatment, and sanitary and humane living conditions.

In the last few years jails have become targets for individual and class action suits (a dozen in 1978 alone), and the conditions in several jails have been declared unconstitutional, based on *Newman* and *Estelle.* Of particular psychiatric interest is the courts’ concern in one case, *Rhem v. Malcolm,* with the mental health of pretrial detainees. In the New York City jail known as “The Tombs,” overcrowding, excessive noise and heat, lack of windows, lack of facilities for exercise, and refusal of contact visits were all judged detrimental to the mental health of inmates.

In spite of those enlightened decisions, progress has been slow. Such judicial actions are relatively few in number and geographically scattered. The substance of them has not yet set a national precedent. A 1976 decision of the United States Supreme Court may exert remedial impact, providing impetus for legislative action to reduce present inadequacies: in *Estelle v. Gamble,* the Court affirmed the protection afforded by the Eighth Amendment.
Amendment and stated that the prohibition of cruel and unusual punishment is violated when serious medical needs of an inmate are unmet.\textsuperscript{4}

\textbf{Mental Illness}

In AMA's health and illness survey and in subsequent site investigations of jail services, the number one health complaint of sheriffs was insufficient care for the mentally ill, including alcoholics, drug abusers and the mentally retarded, and refusal of the average community to accept responsibility for them. As a consequence of the popular public mental hospital deinstitutionalization movement, large numbers of seriously mentally ill are returned to the community. In the wry words of one observer, the previously involuntarily institutionalized have now been involuntarily communitized, often to their disadvantage. A process of criminalization has resulted: many of the disturbed and disturbing are relegated to the criminal justice system. If the mental health system is closed, the penal system will be used. Following the closing of one California state hospital, the sheriff of Santa Clara County reported a 300 per cent increase in his jail population.\textsuperscript{5}

A persistently growing interest in the psychiatrically underserved culminated in the 1975 supplement to the Community Mental Health Centers Act, which mandated twelve services that mental health centers must provide. The new required services include programs for children, aged, chemically dependent including alcoholics, and chronic mental patients in the community. The 1978 report of the President's Commission on Mental Health reiterated the required services, and they were incorporated in the Mental Health Systems Act now before Congress.\textsuperscript{6} Again, however, the legally incarcerated were omitted.

Reliable statistics on the number and type of mentally ill inmates of jails are difficult to establish; there is no satisfactory reporting system. Petrich and colleagues reported that during one year's provision of psychiatric services in a metropolitan jail, 524 inmates were referred, primarily by the custodial staff, for psychiatric evaluation.\textsuperscript{7} Of the group, thirty per cent were diagnosed schizophrenic and eight per cent organic brain syndrome. Petrich observed that the referred inmates were mostly violent, disordered, bizarre or suicidal; in other words, those who upset the custodial staff. The quietly ill and mentally retarded were notably under-represented in their patient sample.

Swank and Winer, after a similar one-year investigation in a large jail, reported comparable results.\textsuperscript{8} They received 445 referrals among whom 29 per cent were psychotic and three per cent mentally deficient. Two per cent manifested a seizure disorder. To sample the incidence of psychiatric disorders in a total jail population, they screened 100 consecutive jail admissions and found five per cent psychotic, one per cent mentally retarded, and one per cent suffering a convulsive disorder. Adding all these efforts and the AMA survey and site visiting data together, it can be reasonably assumed that the average jail will, through sufficiently accurate psychiatric screening, find among its inmates a fifty per cent incidence of alcohol and drug abuse, five per cent psychoses, and fifteen per cent with non-psychotic but severe emotional problems. In addition, there will be 1-2 per cent mentally retarded and 2-3 per cent with seizure problems.
Swank and Winer report difficulties in finding suitable psychiatric placement for the severely disturbed. They were unable to move even the most obviously psychotic individuals from jail for any substantial length of time. Some were returned to jail four or five times in spite of being successively released to a hospital. They declare it tragic that large numbers of severely ill persons must be dealt with by a community’s jails rather than by its psychiatric resources.

Certification

By mid-1977 the twentieth field-tested and repeatedly revised draft of the medical standards for jails seemed near final form. After formal approval by the AMA Board of Trustees and the House of Delegates, the set of standards was distributed to jails in the six pilot states along with invitation to apply for certification. A survey team evaluated each applicant jail. The National Advisory Committee then granted or denied certificates on the basis of results and recommendations from its accreditation subcommittee. Thus far over 50 jails have been accredited, and more are being surveyed and processed.

Late in 1978, ten more states joined the project, and in July, 1979, another ten states qualified. Funding for the project has been renewed by LEAA, and the goal is to involve 50 state medical societies in assuming responsibility for promoting physical and psychiatric care of jail inmates.

Expansion

Reasonably satisfied with its jail standards, the project’s members, in 1978, turned attention to prisons and juvenile institutions. Two task forces composed of experts in their respective fields designed, field-tested, revised, and completed a set of standards based mostly on modifications of and additions to the jail standards. These new standards have been approved by the Advisory Committee.

In self-scrutiny the Advisory Committee, noting that its standards lacked adequate consideration of mental health problems, including substance abuse, appointed two more task forces who gave special attention to realistic guidelines for managing psychiatric illness and chemical dependence. Recommendations of those two groups were incorporated into the jail, prison and juvenile institutional standards.

Innovative Services

One original goal of the project was to stimulate experimentation and innovation in the devising of model health care services and delivery systems in jails. Several state medical society committees, local physicians, and jail administrators have demonstrated ingenuity in discovering techniques to meet manifest deficiencies in their pilot jails despite restrictive budgets. Among methods tested were maximal use of physician’s assistants, assignment of nurse-practitioners to women patients, training correctional officers in small jails in health screening skills, activation of a regional traveling medical team to serve several rural jails, and establishment of a uniform medical records system for all the jails in a state.
Information

In support of the main thrust of the field work and standards development the clearing-house component of the project has been as busy as any other. It has accumulated a library of medical and legal data including court decisions; prepared a comprehensive bibliography; and has written and published 19 informative monographs on such diverse subjects as the role of state and local medical society committees, applicability of volunteers in jails, recognition of mental illness in inmates, constitutional issue of prisoners' rights to health care, use of allied health personnel in jails; and has produced a 22-minute award winning documentary film, "Out of Sight, Out of Mind."

Evaluation

The independent research organization has monitored the project as it evolved and has devised and utilized a number of instruments to determine how nearly the project was meeting its ongoing timetable and stated goals. An annual report to LEAA and AMA outlined progress, weaknesses and deficiencies together with suggestions for improvements. The research staff spent much time in the field observing the state committees and individual jails and helping them organize their efforts and realize their objectives.

Conclusions

In the fourth year of the project we are gratified by how much has been accomplished. We have experienced the usual unpredictable delays, differences of opinion, false starts, dead-ends, changing regulations, and frustrating red tape. The most persistent problem, not necessarily the most difficult, has been constant attempts to nibble away at the number and quality of the Standards by a wide variety of well-meaning but unthinking persons. The Advisory Committee has been hard pressed at times to hold the line in the face of complaints that the Standards are too high, too unrealistic, too costly and too difficult to implement. We have, however, held the line and insisted that those Standards are indeed the minimal requirements the medical profession can sponsor. As the project progressed, our stand was buttressed by the number of jails, small, medium and large, urban and rural, that met the specified Standards and received certification.

All in all, the difficulties have been manageable; steady progress has been maintained. Resultant to diligent efforts of the state medical society committees, 18 of the original 30 pilot jails have, to date, received certification of their medical programs. One of the least anticipated effects is that chronic and convalescent care is now provided in 21 of these jails. Adequate in-house medical clinics are provided by 20 jails. Complete health appraisals are given all inmates within 14 days of admission in 15 jails, and regular sick call is provided in 22 jails. A striking change is that detoxification for both alcohol and drug abusers is now supplied by 21 jails; the number was seven at the start of the project. Regular mental health services are now available in 21 jails. Many other improvements have been made in institutions participating in the program.

The standards are achieving modest national recognition. In response to an expressed concern of Congress, the General Accounting Office conducted a
study of health care in jails and prisons. The 1978 special report of the Comptroller General to Congress from this study quotes extensively from the AMA survey data and standards. The American Correctional Association and National Sheriff's Association have incorporated the AMA medical standards in toto into their general standards for correctional institutions. The Los Angeles County jail, the nation's largest, is facing a class action suit by inmates based chiefly on allegedly inadequate medical (especially psychiatric) services. The federal judge hearing the case requested an AMA survey team's investigation of the jail, using its AMA standards as criteria.

The accomplishments of the project are significant and somewhat surprising, particularly since it has not functioned as a centrally organized, controlled and guided endeavor. The state committees have been granted considerable autonomy; the personnel are mostly voluntary; the political and budgetary conditions in several states vary considerably. In addition, we have necessarily close relationships with the National Sheriff's Association, the American Correctional Association, and the American Public Health Association among others, all with varied interests and needs. Considering the complexity and diversity of all the people, agencies and pressure groups involved, the steady progress of the project is indeed remarkable. The devotion and hard work of the AMA staff is in no small part responsible for this success. But I must salute also the dedication and the belief by all participants, from the AMA Board of Trustees to the jailer in Podunk, that the incarcerated are members of our society with the same medical needs and civil rights as other citizens.

References

1. Hamalin L and Karl FR: The Fourth World: The imprisoned, the poor, the sick, the elderly and the underaged in America. Dell, New York, 1976
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